

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-042820

6069

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6069

FILED DEC 14 1962

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR KANSAS CITY, MISSOURI		c. CITY OR TOWN KANSAS CITY, MO.	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL, KC, MO.		d. STREET ADDRESS 3629 TRACY, KC, MO.	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H. Last NEAL		4. DATE OF DEATH Month NOV. Day 30 Year 19 62	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/3/96
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Engineer		10b. KIND OF BUSINESS OR INDUSTRY State Hospital	9. AGE (last birthday) 66
11a. FATHER'S NAME VIN NEAL		11b. MOTHER'S MAIDEN NAME MYRTLE BAILEY	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME VIN NEAL		14. NAME OF HUSBAND OR WIFE FLORA NEAL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		17. INFORMANT VA HOSPITAL RECORDS Mrs Flora Neal 3629 Tracy, Kc, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO (b) ATHEROSCLEROSIS OF CORONARY ARTERIES DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
21. VA attended the deceased from 10/22/62 to 11/30/62 and last saw him alive on 11/30/62 Death occurred at 9:00 PM 11/30/62 m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Seymour Bakeman</i> (Degree or title) M.D.		22b. ADDRESS VA Hospital, K. C. MO.	22c. DATE SIGNED 12-1-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-1-1962	23c. NAME OF CEMETERY OR CREMATORY Mont Ida Cemetery	23d. LOCATION (City, town, or county) Mont Ida, Kansas (State)
24. FUNERAL DIRECTOR Eugene P. Amos Shawnee, Kansas		25. DATE RECD. BY LOCAL REG. 12-1-62	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Seymour Bakeman

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

VS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Leahue P. Amos
Licensed Embalmer No. 5023

P. O. Address Shawnee, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

5-1-1-01